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INDIVIDUAL HEALTH CLAIMS (417)

INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
FOR

7-1-98

RESIDUAL DISABILITY BENEFITS

	H-538069
Name	in Full (11/RISTOPHER KEARNEY Policy No. H-493629
1.	
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	unable to work as many his.
	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 8/66 (to the nearest dollar.)
	I used the $(A) \stackrel{\checkmark}{\smile}$ prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year 00 6 98
1	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 7-1 1998 Signed (Claimant) (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

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/P		U	
V /			_

~ H-538069 Name in Full (HRISTOPHER KEARNET Policy No. H-493029 2/8 1993 to present 19_ I was residually disabled from ___ During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____ __or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 of the time usually required to perform these duties. I expect to return to the full performance of my occupation on 3. not sure 19. NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BOMUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 5166 (to the nearest dollar.) I used the (A) \checkmark prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average. My monthly income for each month for which claim is being made is as 5.

follows:

Amount Month Year Amount Month Year Amount Month Year

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-1-98 19 Signed histyl Kearny (Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
lane	in Full (HRISTOPHER KEARNEY Policy No. H-493629
L.	2/0 00 4 00 1
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	<u> </u>
	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
,	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \frac{\fra
	I used the (A) $\stackrel{\checkmark}{\swarrow}$ prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
\$	Amount Month Year Amount Month Year Amount Month Year 2000 8 98
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 9-1 1998 Signed Christy L Klearny (Claimant)
	(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

						•	H-S	538069	
ama	in Full_	CHRIS	TOPHE	a KEI	ARNEY	Policy N	10. H-49	13629	_
•	I was res	idually	disable	d from	2/8	_19 <u><i>93</i></u>	to presen	<u>t</u> 19:	
	Pro	ic mari	ad of ro	sidual di	sability	I was ((A) unable my occupat	to perform	-
-	the usual of the t	l daily i	business	duties C	f my occ	rupation.	a to perfor , but only ties.	m all of for 65	_ .¥
•		to retu	rn to ti	e full pe			occupation	on	
	MONTHLY : REMUNERA! EXPENSES PERFORME: ANNUNITI	INCOME FION, AF BUT BEF D BY YOU ES OR OT	ROM SALI TER DEDI ORE DEDI DO NO HER FORM	RY, WAGES ICTION OF ICTION OF IT INCLUDE IS OF UNE	NORMAL I NORMAL I ANY INCO DIVIDED ARNED INC	AND CUSTOME TAXES NDS, RENT COME.	AND 5, INC ISSIONS, FE OMARY BUSIN S, EARNED I TS, ROYALTI	ESS FOR SERVICE (ES,	
•	consecut	ive mont ater) w	ths immed is \$ 8/	iiately p	(to the	nearest	or the tweld of total dollar.)	473cm24-1	<i>.</i>
	I used t	the (A) <u>r</u> earnings	_ prior to dete	calendar	year (B s averag	} pri e.	or twelve	consecut;	
5.	My month follows:	ly incom	me for e	ach month	for whi	ch claim	is being	D r	
	Amount			Amount	Month	Year	• 15824		
	<u>eo</u>	9	<u>98</u>						
	Any info	ormation furnish	nacessa ed upon	ry to ver request.	ify the	answers	I have giv	€).	
					α_{l}		, ,		* 2r
	Date 10	-/	19 <u>98</u>	Signed (hrist	(Clai	imant)		
	•				•	٠	•		

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

		,				•	H-'	538069	9
Name	in Full	(IHRIS	TOPHE	a KE	ARNEY	Policy N	o. <u>H-4</u>	93029	}
1.	I was re	sidually	disable	d from	2/8	_19 <u><i>93</i></u>	to presen	rt_19_	•
2.	During to the foll	his perio	od of re portant	sidual di daily bus	sability iness du	I was (ties of	A) unable my occupa	to perf tion	orm
	the usua of the t	l daily l	ousiness lly requ	duties o	or (B) I of my occ perform t	was able upation, hase dut	to perfo but only	rm all o	5 +
3.	I expect	to retur	rn to th	e full pe	rformanc	e of my	occupatio	n on	٠
	MONTHLY REMUNERA EXPENSES PERFORME	INCOME FOR THE STATE OF THE STA	ROM SALA TER DEDU ORE DEDU . DO NO	RY, WAGES ICTION OF ICTION OF	S, BONUSE NORMAL A ANY INCO E DIVIDEN	S, COMMI IND CUSTO IME TAXES IDS, RENT	AND 5, IN ISSIONS, F MARY BUSI B, EARNED IS, ROYALT	EES OR (NESS FOR SER!	
4.	consecut	ive mont	hs immed	liately p	rior to m	y period	or the twe i of total dollar.)	lve disabil	Lity
	I used to months	the (A) <u>/</u> earnings	_ prior to deter	calendar	year (B) s average	pri	or twelve	consecu.	tive
5.	My month	nly incom	e for ea	ach month	for which	ch claim	is being	made is	as
	Amount	<u>Month</u>	Year	Amount	Month	Year	Amount	Month	Year
	0_	10	98						
ž	will be	furnishe	ed upon :	request.			I have giv		e
	Date_//	- 2	19 <u>98</u>	Signed_(Muslo	Clai	L Leas mant)	nez	

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

		•					, , ,	53806	
ame	in Full	CHRIS	TOPHE	ER KE	ARNEY	Policy N	o. <u>H-4</u>	9302	2
L.	I was re	sidually	disable	ed from	2/8	_19 <u><i>9</i>3</u>	to present	nt 19_	_:
2.	During t the foll	his peri owing im	od of re portant	esidual di daily bus	sability siness du	I was (ties of	A) unable my occupa	to peri	form
	the usua	l daily	busines 11y req	s duties duried to p	I W OCC	upation.	to perfo but only	rm all of for 6	0 <u>f</u> }
3.	I expact	to retu	rn to ti	he full pe	riormano	e of my	occupatio	n on	
	MONTHLY REMUNERA EXPENSES PERFORME	INCOME FATION, AF BUT BEF ED BY YOU	ROM SALI TER DEDI ORE DEDI	ARY, WAGES UCTION OF UCTION OF	S, BONUSE NORMAL A ANY INCO E DIVIDEN	ES, COMMI AND CUSTO OME TAXES IDS, RENT	AND 5, IN ISSIONS, F DMARY BUSI I, EARNED IS, ROYALI	EES OR (NESS FOR SER	
4.	consecut	zīve mont	hs imme	me for the diately po	rior to m	y period	or the twe i of total dollar.)	lve disabi	lity
	I used to	the (A) <u>/</u> earnings	_ prior to dete	calendar	year (B) s average	prid	or twelve	consecu	tive
5.	My month	nly incom	e for e	ach month	for which	ch claim	is being	made is	as
	Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
	0		98						
i	will be	furnishe	ed upon	request.	•		I have giv		' &
	Date_/2	2-/	19 <i>_58</i>	Signed_	Shust	1Class	Lear mant)	ney	
						1			

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT

For RESIDUAL DISABILITY BENEFITS

								53806	
Name	in Full	CHRIS	TOPHE	a KE	ARNEY	Policy N	o. <u>H-4</u>	93629	2
1.	I was res	sidually	disable	d from _	2/8	_19 <u><i>93</i></u>	to presen	nt_19_	_·
2.	During the the following	his perio	od of re portant	sidual di daily bus	sability iness du	I was (ties of	A) unable my occupa	to perf tion	iorm ——
	the usua of the t	l daily	business	duties o	f by occ	upation.	to perfo but only	rm all o	5 t
3.	I expect	to ratu	rn to th	e full po	rfocunc	e of my	occupatio	n on	
	MONTHLY REMUNERA EXPENSES PERFORME	INCOME F TION, AF BUT BEF D BY YOU	ROM SALA TER DEDU ORE DEDU . DO NO	LRY, WAGES ICTION OF ICTION OF	S, BONUSE NORMAL A ANY INCO E DIVIDEN	IS, COMMI AND CUSTO ME TAXES IDS, RENT	AND 5, IN ISSIONS, F MARY BUSI 3, EARNED IS, ROYALT	EES OR (NESS FOR SER	
4.	consecut	ive mont	hs immed	ne for the liately pr	rior to s	y period	or the twe l of total dollar.)	lve disabil	Lity
	I used to months e	the (A) <u>/</u> earnings	_ prior to deter	calendar rmine this	year (B)	prid	or twelve	consecu.	tive
5.	My month follows:	ly incom	e for e	ach month	for which	th claim	is being	made is	as
,	Amount 1000.00			Amount	Month	Year	Amount	Month	Year
:	Any info	rmation furnishe	necessa: ed upon :	ry to ver request.	ify the a	inswers	I have giv	ven abov	' e .
	Date_ /-	. 4	99 19	Signed_(hunt	plick (Clai	earner		
				A:160		(Clai	mant)		

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMATT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

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Name	in Full	CHRIS	TOPHA	ea KE	ARNEY	Policy 1	No. H-	19362	9
1.	I was re	sidually	disable	ed from	2/8	19 <u><i>93</i></u>	to prese	nt_19_	_:
2.	During t the foll	his peri lowing in	od of reportant	esidual di daily bu	isability Siness di	y I was uties of	(A) unable my occupa	to per	form ———
•	the usua of the t	al daily ime usua	busines	s duties (of my occ	rupation	e to perfo , but only ties.	orm all for _4	of 5 *
3.	I expect	to retr	rn to ti	he full po	erformend	ce of my	occupation	on on	
	MONTHLY REMUNERA EXPENSES PERFORMS	INCOME E ATION, AS BUT BES ED BY YOU	TROM SAL TER DEDI ORE DEDI	ARY, WAGE: UCTION OF UCTION OF	NORMAL ANY INCO	ES, COMM AND CUSTO OME TAXE NDS, REN	AND 5, IN ISSIONS, E OMARY BUSI S, EARNED IS, ROYALI	TEES OR INESS FOR SER	•
4.	consecut	cive mont	hs imme	diately p	rier to 1	ry period	or the two i of total dollar.)	alve disabi	lity
	I used to months	the (A) <u>V</u> sarnings	_ prior to dete	calendar rmine thi	year (B) s average	pri	or twelve	consecu	tive
5.	My month follows:	nly incom	me for e	ach month	for which	ch claim	is being	made is	as
	Amount 4500.00	Month /	<u>1921</u>	Amount	Month	Year	Amount	Month	Year
;	Any info will be	ormation furnishe	necessa: ed upon :	ry to ver request.	ify the a	inswers :	I have giv	ven abov	' G
	Date	2-1	19 <i>_9</i> /	Signed_(Thurs	(Clair	L Kea	0	

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INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMAT'S STATEMENT -FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
	in Full (HRISTOPHER KEARNEY Policy No. H-493629
ı.	I was residually disabled from 2/8 1993 to present 19.
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	
	the usual daily business duties of my occupation, but only for 65 to fine usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \[\frac{\beta/\beta}{\lambda} \] (to the nearest dollar.)
	I used the $(A) \stackrel{\checkmark}{\checkmark}$ prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
3	Amount Month Year Amount Month Year Amount Month Year 1000 2 99
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 3-3 1999 signed Christopher L. Kearney (Claimant)

39 HAR -8 PM 1: 56 TIP-IHI-GAVIANIN

Jefferran-Pilot Fizacial Supplemental Claimant's Statement For Residual Disability Benefits

Namé is	r Full	HRISTO	PHER	KEA	RNEY	· P	olicy No. <u></u>	-5380 1-493	69
I.	l was resid	lually disab	led from	2:-8		93 To <i>()</i>	mosent	*	
2.		s period of uties of my	occupatio	in .			n the followin		
•	ту оссира	ation, but o					he usual daily to perform the		ties of
3.	l expect to	return to 1	the full pe	rformance of	my occupat	ion on 🕢	not su) <u> </u>	
	FROM SAL DEDUCTION INCOME T	ARY, WAGE In of Nori Axes, Eari	S, BONUS TAL AND (KED FOR !	ES, COMMISS CUSTOMARY	CIONS, EEES (Busi <mark>ness e</mark> x Began es by	OR OTHER I IPENSES BU I YOU. DO	INCLUDE MOI REMUNERATIO IT BEFORE DE NOT INCLUDE	IN, AFTER DUCTION OF	ANY
4.							secutive mon		
		(A) this average	_ ,	alendar year	(8)pri	ior twelve o	onsecutive m	onths earnin	gs to
5.	My month	ly income f	cr each m	onth for whi	ch a dain is	being mad	e is as follows	:	
	<u>Amount</u>	<u>Month</u>	<u>Year</u>	Amount	Mond	Year	<u>Amount</u>	<u>Month</u>	<u>Year</u>
	00	3	99						
	Any infor	mation neco	essary to v	erify the ans	wers i have	given above	will be furnis	i hed upon re	quest.
	Date	1-6-	19 9	9 Signed	Chu	stopl	<u>Kes</u>	ny	
						(13210)	antj		

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JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H538069
Nam	in Full CHRISTOPHER KEARNEY Policy No. H493029
1.	I was residually disabled from 2-8 1993 to gresent 19
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the
	usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $\$$ 8166 (to the nearest dollar.)
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
	00 4 99
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 5-1 1999 Signed Christysh L. Kenny (Claimant)
	·

99 MAY -3 PH 2:21 THE-INI-DIAMEDIN

JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H 538069
Name	in Full CHRISTOPHER L. KEARNEY Policy No. H 493029
	I was residually disabled from 2/8 1993 to grount 19_
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the
	usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 8166 (to the nearest dollar.)
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
	100.00 <u>5</u> <u>99</u>
2	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 6-14 1999 Signed Christoph L Claimant)
	PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION

ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H-538069
Nam	in Full (HRISTOPHER KEARNEY Policy No. H-493629
ı.	
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 to the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
-	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ \frac{\fir}{\fint}\fint}{\frac{\fr
	I used the (A) \checkmark prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year 00 6 99
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 7-5 1999 Signed (Mustophen Kearney (Claimant)
	,

JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H 538069
Name	in Full CHRISTOPHER L. KEARNEY Policy No. H 493029
1.	was residually disabled from 2/8 1993 to prosent 19
	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the
	usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $\frac{8/66}{}$ (to the nearest dollar.)
•	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
	0 7 99
:	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 8.1 199 Signed Misstophe L Kearney (Claimant)
	TULLY COMPLETED CURRICHTAL

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JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

							, ,	53806	
N a m c	e in Full	CHR157	OPHER	L. KE	aRNEY.	Policy	No. 11	4930	39
1.	I was re	sidually d	isabled	from 2	18	19 <u>93</u> t	o pro	ent 19	
2.	Miles and Br	his period owing impo	OF THE	idusi disa	bility I	was (A) unable	to per	
				or (B) I was	able to	perform	all of	the
	usual da of the t	ily busine ime usuall	ss dutio v requi	es of my ores	ccupation form	n, but se duti	only for es.	- 45	
3.	I expect	to return	to the	full perf	ormance	of my o	ccupatio	оп оп	
	MONTHLY OTHER RE EXPENSES PERFORME	OR PURPOSES INCOME FROM MUNERATION BUT BEFOR ED BY YOU. IES OR OTH	M SALAR I. AFTER RE DEDUC DO NOT	Y, WAGES, DEDUCTION TION OF AN INCLUDE I	BONUSES, OF NORM Y INCOME VIVIDENDS	COMMIS IAL AND TAXES, RENTS	CUSTOMAI EARNED	RY BUSIN	IESS RVICES
4.	consecul	age monthly tive month: eater) was	s immedi	ately pric	or to my	period	or tota.	r atzan.	llity
	I used (the (A) <u>v</u> earnings t	_prior c o determ	alendar ye ine this e	ear (B) average.	priox	twelve	consect	ıtive
5,	My month	hly income :	for eac	h month fo	or which	claim :	ls being	made i	s as
	Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
•	100	8	99			·			
;	Any info	ormation n furnished	ecessary	to verif	y the an	swers I	have gi	ven abo	ve
	Date	9-1.	19/	Signed_(Muin	(Claim	Kes ant)	7	

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

				a		, ,	53806	
in Full	CHRIST	TOPHER	L. KE	ARNEY	Policy	No. 77	4930.	<u> </u>
I was res	sidually o	disabled	from	1/8	_19 <u><i>93</i></u>	to fra	unt 1	9
During the	nis perio owing imp	d of res ortant d	idual disa aily busin	bility I less duti	was (les of	A) unabl	e to per ation	rform
usual da of the t	ily busin ime usual	ess duti ly requi	es of my or red to per	ccupation form	n, but se dut	only fo	r <u>65</u>	<u>~</u> "
I expect	to retur	n to the	full peri	ormance	of my	occupati	on on	
MONTHLY OTHER RE EXPENSES PERFORME	INCOME FR MUNERATIO BUT BEFO D BY YOU.	OM SALAR N, AFTER RE DEDUC DO NOT	Y, WAGES, DEDUCTION TION OF AN INCLUDE I	BONUSES, OF NORI V INCOMI VIVIDENDS	, COMMI AAL AND E TAXES G, RENT	SSIONS, CUSTOMA , EARNED	RY BUSI	NESS
consecut	ive month	s immedi	ately pric	or to my	period	of tota	I disab	ility
I used t	he (A) $ u$ arnings t	prior co determ	alendar ye	ear (B)_ average.	prio	r twelve	consec	utive
		for eac	h month fo	or which	claim	is being	made i	s as
Amount	Month	<u>Year</u>	Amount	Month	Year	Amount	Month	Year
00	9	99						
	usual date of the tale of	usual daily busin of the time usual lexpect to return the motion of the time usual lexpect to return the motion of the time usual lexpect to return the motion of the time usual lexpect to return the motion of the greater of the least of the greater of the least of the greater of the least o	usual daily business duti of the time usually requi I expect to return to the	During this period of residual disathe following important daily business duties of my of the time usually required to per of the time usually required to perform the time time that the time that	During this period of residual disability of the following important daily business duties of my occupation of the time usually required to perform the sequence of the time usually required to perform the sequence of the time usually required to perform the sequence of the time usually required to perform the sequence of the time usually required to perform the sequence of the time usually required to perform the sequence of the time usually required to perform the sequence of the sequence of the calendar sequence of the sequence of the calendar consecutive months immediately prior to my sequence of the sequence of	During this period of residual disability I was (the following important daily business duties of or (B) I was able t usual daily business duties of my occupation, but of the time usually required to perform these dut I expect to return to the full performance of my	During this period of residual disability I was (A) unable the following important daily business duties of my occupation. OR (B) I was able to perform usual daily business duties of my occupation, but only for of the time usually required to perform these duties. I expect to return to the full performance of my occupation of the time usually required to perform these duties. NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, IN MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMA EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYAL ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME. My average monthly income for the calendar year or the two consecutive months immediately prior to my period of total (the greater) was \$	During this period of residual disability I was (A) unable to per the following important daily business duties of my occupation or (B) I was able to perform all or usual daily business duties of my occupation, but only for of the time usually required to perform these duties. I expect to return to the full performance of my occupation on 19 NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSI EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SE PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disab (the greater) was \$ (to the nearest dollar.) I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average. My monthly income for each month for which claim is being made if follows:

DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION

ON THE BACK OF THAT FORM.

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JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) "" PLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H 538069
Nan	ne in Full CHRISTOPHER L. KEARNEY Policy No. H 493029
1.	I was residually disabled from 2/8 1993 to prosent 19
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the
	usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICE PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $\frac{8166}{}$ (to the nearest dollar.)
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
# j	Amount Month Year Amount Month Year Amount Month Year
ι -	9 99
	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 10-1-99 19 Signed thustopher L. Kearney (Claimant)
	PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL

DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION

ON THE BACK OF THAT FORM.

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Case 1:02-cv-00479-MRB Document 30-11 Filed 02/16/2004 Page 36 of 44

JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (4170) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR

RESIDUAL DISABILITY BENEFITS

	H 538069
Nam	e in Full CHRISTOPHER L. KEARNEY Policy No. H 493029
1.	I was residually disabled from 2/8 1993 to great 19_
2.	During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the
	usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$ 8/66 (to the nearest dollar.) I used the (A) prior calendar year (B) prior twelve consecutive
	months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
	11-50-99 00 '99
	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 11-30-99 19 Signed histysh Kearn (Claimant)

BOEC-P BH S: 23 - CONTRACT - THE - HILL

FAX NO. : Jun. 26 1999 04:37Am P3 Case 1:02-cv-00479-MRB Document 30-11 Filed 02/16/2004 Page 38 of 44

JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (5315) SUPPLEMENTAL CLAIMANT'S STATEMENT **FOR** RESIDUAL DISABILITY BENEFITS

	Name in Full Aller Tullel War aller 1 1022-20
	Name in Full AHRISTUPHER L. KEARNOTOLICY No. 14 493029
	1. I was residually disabled from1993 to19
	2. During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the usual daily
	business duties of my occupation, but only for 65% of the time usually required
	to perform these duties.
	3. I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME. 4. My average monthly income for the calendar year or the twelve consecutive months
	immediately prior to my period of total disability (whichever is greater) was \$ 8/66 (to the nearest dollar).
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
	5. My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
	\$ 2000° 12 99
\$ \$	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 12-30 1999 Signed Minitoshe L. Kenn
	(Claimant)
	0
	PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL

DISABILITY CLAIM REPORT. BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION

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ON THE BACK OF THAT FORM.

Stant Alika Sagar

JEFFERSON-PILOT LIFE INSURANCE COMPANY **INDIVIDUAL HEALTH CLAIMS (5315)** SUPPLEMENTAL CLAIMANT'S STATEMENT FOR RESIDUAL DISABILITY BENEFITS

Na	ame in Full CHRISTOPHER KEARNEY Policy No. H 493029
	I was residually disabled from1993 to fresht 19
2.	During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation
	or (B) I was able to perform all of the usual daily
	business duties of my occupation, but only for 65% of the time usually required to perform these duties.
3.	I expect to return to the full performance of my occupation on <u>not sure</u> 19
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (whichever is greater) was \$
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
	Amount Month Year Amount Month Year Amount Month Year
#	2000 / 2000
	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 21-2000 19 Signed Montople d. Kenny (Claimant)

JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (5315) SUPPLEMENTAL CLAIMANT'S STATEMENT FOR RESIDUAL DISABILITY BENEFITS

Na	ume in Full CHRISTOPHER KEARNEY Policy No. H 493029
	I was residually disabled from1993 to19
2.	During this period of residual disability, I was (A) unable to perform the following important daily business duties of my occupation
	or B I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required
	to perform these duties.
3.	I expect to return to the full performance of my occupation on
	NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER RENUMERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.
4.	My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (whichever is greater) was \$_8166 (to the nearest dollar).
	I used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
5.	My monthly income for each month for which claim is being made is as follows:
9	Amount Month Year Amount Month Year Amount Month Year
H	2000 / 2000
	Any information necessary to verify the answers I have given above will be furnished upon request.
	Date 3-1 19200 Signed Christopher Kenny (Claimant)

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JEFFERSON-PILOT LIFE INSURANCE COMPANY INDIVIDUAL HEALTH CLAIMS (417) SUPPLEMENTAL CLAIMANT'S STATEMENT For RESIDUAL DISABILITY BENEFITS

e in Full CHRISTOPHER L KEARNEY Policy No. H 493029/H.
I was residually disabled from 2/8 1993 to present 19.
During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation
the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.
I expect to return to the full performance of my occupation on
NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.
My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was \$\frac{8166}{166} (to the nearest dollar.)
used the (A) prior calendar year (B) prior twelve consecutive months earnings to determine this average.
fy monthly income for each month for which claim is being made is as
mount Month Year Amount Month Year Amount Month Year
ny information necessary to verify the answers I have given above ill be furnished upon request.

DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION

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